3.7. Self-Identification. Air Force members with substance abuse problems are encouraged to seek assistance from the unit commander, first sergeant, substance abuse counselor, or a military medical professional. Following the assessment, the ADAPT Program Manager will consult with the Treatment Team, and determine an appropriate clinical course of action.

3.7.1. Drugs.

3.7.1.1. An Air Force member may voluntarily disclose evidence of personal drug use or possession to the unit commander, first sergeant, substance abuse evaluator, or a military medical professional.

3.7.1.2. Commanders will grant limited protection for Air Force members who reveal this information with the intention of entering treatment.

3.7.1.3. Commanders may not use voluntary disclosure against a member in an action under the Uniform Code of Military Justice (UCMJ) or when weighing characterization of service in a separation.

3.7.1.4. Disclosure is not voluntary if the Air Force member has previously been:

3.7.1.4.1. Apprehended for drug involvement.

3.7.1.4.2. Placed under investigation for drug abuse. When a member is considered *"placed under investigation"* is determined by the circumstances of each individual case. A member is under investigation, for example, when an entry is made in the Security Forces blotter, when the Security Forces Investigator's log shows an initial case entry, or when the Office of Special Investigations (OSI) opens a case file. A member is also considered under investigation when he or she has been questioned about drug use by investigative authorities or the member's commander, or when an allegation of drug use has been made against the member.

3.7.1.4.3. Ordered to give a urine sample as part of the drug-testing program in which the results are still pending or have been returned as positive.

3.7.1.4.4. Advised of a recommendation for administrative separation for drug abuse.

3.7.1.4.5. Entered treatment for drug abuse.

3.7.1.5. The limited protection under this section for self-identification does not apply to:

3.7.1.5.1. The introduction of evidence for impeachment or rebuttal purposes in any proceeding in which the evidence of drug abuse (or lack thereof) has been first introduced by the member.

3.7.1.5.2. Disciplinary or other action based on independently derived evidence (other than the results of commander-directed drug testing), including evidence of continued drug abuse after the member initially entered the treatment program.

3.7.2. Alcohol. Commanders must provide sufficient incentive to encourage members to seek help for problems with alcohol without fear of negative consequences.

3.7.2.1. Self identification is reserved for members who are not currently under investigation or pending action as a result of an alcohol-related incident.

3.7.2.2. Self-identified members will enter the ADAPT assessment process and will be held to the same standards as others entering substance abuse education, counseling and treatment programs.

3.8. Commander's Identification and Associated Roles and Responsibilities .

3.8.1. A unit commander shall refer all service members or for assessment when substance use is suspected to be a contributing factor in any incident, e.g., DUI, public intoxication, drunk and disorderly, spouse/child abuse and maltreatment, under-aged drinking, positive drug test, or when notified by medical personnel under para **3.9.1.** -3.9.3. of this instruction. (Commanders who fail to comply with this requirement place members at increased risk for developing severe substance abuse problems and jeopardize the mission)

3.8.2. Commander or first sergeant closely examines all DD Form 1569, Incident Complaint Record, for evidence of substance use or abuse.

3.8.3. After coordination with the Staff Judge Advocate, unit commanders will direct drug testing within 24 hours of suspected alcohol related incidents of misconduct, episodes of aberrant or bizarre behavior, or where there is reasonable suspicion of drug use and the member refuses to provide consent for testing. Commanders are also encouraged to ensure Blood Alcohol Tests (BAT) are taken as soon after the incident as possible to determine the level and intensity of alcohol involvement.

3.8.4. The unit commander contacts the installation's ADAPT staff within 7 days of the incident to initiate the assessment process. In incidents of DUI/DWI, the commander will refer the individual to the ADAPT office as soon as possible. The ADAPT staff will complete the initial assessment within 7 days of the commander's suspension of the individuals base driving privileges.

3.8.4.1. If the individual involved in the incident is TDY, the commander at the deployed location determines if the member must return to the permanent duty station. If the member does not return to the permanent duty station, then the ADAPT staff at the TDY location conducts the substance abuse assessment.

3.8.5. Commander refers individuals under investigation for drug abuse for assessment after the commander prefers charges (that is, signs DD Form 458, Charge Sheet). Commanders who elect not to prefer charges but suspect the individual of drug abuse must refer members for a substance abuse assessment as soon as possible.

3.8.6. The commander provides information to the ADAPT program office to assist in the assessment (e.g., BAT results), including comments on observed performance and behavior to the substance abuse staff before the assessment appointment.

3.8.7. The commander directs the member's immediate supervisor to contact the ADAPT staff before the assessment to provide pertinent information on the patient's duty performance, on and off duty behavior, or other incidents.

3.8.8. The commander tells the member:

3.8.8.1. The reason for the assessment.

3.8.8.2. That the assessment is not punitive in nature.

3.8.8.3. That the member must report in uniform for the substance abuse assessment appointment at the appointed date and time.

3.8.9. The commander ensures the assessment and treatment of personnel is not delayed by ordinary leave or TDYs.

3.8.10. The commander is responsible for all personnel/administrative actions pertaining to patients involved in the ADAPT program, to include assignment availability, promotion eligibility, reenlistment eligibility, PRP, Security Clearance, etc. Application of administrative restrictions should be based on the establishment of a UIF or control roster resulting from the member's unacceptable behavior and not solely based on their involvement in the ADAPT program.

3.8.11. The Commander will actively participate on the Treatment Team (TT) by providing input to treatment decisions. Command involvement is critical to a comprehensive substance abuse treatment program, particularly in the prevention and early intervention stages, as well as during aftercare and follow-up activities. The commander shall also provide command authority to implement the treatment plan when the member does not voluntarily comply with the TT's decisions.

3.9. Medical Care Referrals.

3.9.1. Medical personnel must notify the unit commander and the ADAPTPM when a member:

3.9.1.1. Is observed, identified, or suspected to be under the influence of drugs or alcohol.

3.9.1.2. Receives treatment for an injury or illness that may be the result of SA.

3.9.1.3. Is suspected of abusing substances.

3.9.1.4. Is admitted as a patient for alcohol or drug detoxification.

Section 3D—Assessing Members for Substance Abuse

3.10. Purpose. The central purpose of the SA assessment is to determine the patient's need for treatment and level of care required.

3.10.1. ADAPT Staff Members :

3.10.1.1. Schedule all assessment appointments upon notification of the referral. Referral information will be documented on the SF 600, Chronological Record of Medical Care.

3.10.1.2. Conduct the substance abuse assessment within 7 duty days of notification.

3.10.1.3. Before the assessment appointment, explain to the patient's supervisor:

3.10.1.3.1. The requirement that the supervisor provide information on the patient's duty performance and on- and off-duty behavior.

3.10.1.3.2. The current status and requirements of the member.

3.10.1.3.3. Limits of confidentiality.

3.10.1.3.4. The counselor's responsibilities.

3.10.1.3.5. The assessment process.

3.10.1.4. Before eliciting information from the patient, brief the patient on:

3.10.1.4.1. Stipulations of self-identification, if applicable

3.10.1.4.2. Limits of confidentiality

3.10.1.4.3. Privacy Act provisions

3.10.1.4.4. Overview of ADAPT to include program rules and patient rights and responsibilities.

3.10.1.4.5. The mental health technician/drug/alcohol counselor's responsibilities

3.10.1.4.6. The purpose, access, and disposition of mental health records

3.10.1.4.7. The option and consequences of refusing treatment

3.10.1.5. During the initial assessment, brief patients being considered or processed for separation on their entitlement to substance abuse treatment with the Veterans Administration (VA).

3.10.1.6. Include in the assessment, as appropriate:

3.10.1.6.1. Referral information.

3.10.1.6.2. Biopsychosocial history and current status.

3.10.1.6.3. Occupational, social, financial, and legal history.

3.10.1.6.4. History of substance use or abuse.

3.10.1.6.5. Medical problems.

3.10.1.6.6. Mental status exam.

3.10.1.6.7. A preliminary diagnostic impression.

3.10.1.6.8. Substance abuse treatment recommendation.

3.10.1.7. If the patient is TDY or on leave, contact the member's home base and inform them of the substance abuse-related incident and the status of the assessment process.

3.10.2. ADAPT Program Managers:

3.10.2.1. Provide supervision for Certified Substance Abuse Counselors IAW AFI 44-119 or other Air Force policy.

3.10.2.2. Conduct required reviews of the patient's medical records and all documentation provided by the substance abuse staff on a priority basis.

3.10.2.3. Observe the patient's general physical and mental condition during the assessment. Refers for additional medical, psychiatric, or laboratory examinations as needed.

3.10.2.4. Chair Treatment Team (TT) Meetings.

3.10.2.5. Refer military members identified for illicit or illegal drug abuse or members diagnosed with Alcohol Abuse or Alcohol Dependence for human immunodeficiency virus (HIV) testing.

3.10.3. Alcohol and Drug Abuse Counselors

3.10.3.1. Certified Alcohol and Drug Abuse Counselors (CADAC) provide treatment services IAW AFI 44-119, "Licensure, Certification, or Registration of Health Care Personnel," in the following 12 core functions as outlined by the International Certification & Reciprocity Consortium (ICRC) and the Air Force Substance Abuse Counselor Certification Handbook: screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, patient education, referral, reports and record keeping, and consultation.

3.10.3.2. Non-certified substance abuse counselors who are in training may conduct the 12 core functions only when directly supervised by a CADAC or privileged provider.

3.11. Using Assessment Results .

3.11.1. Information gathered during the assessment will form the basis for patient diagnosis, treatment planning, and delivery of substance abuse services.

3.11.2. Except in cases of self-identification, information the patient provides in response to assessment questions may be used in a court-martial and to characterize service at the time of discharge. Such evidence may be introduced for other administrative purposes or for impeachment or rebuttal purposes in any proceeding in which the patient introduced evidence of substance abuse (or lack thereof).

3.11.3. Before adjudication, the ADAPT provider will provide assessment results on individuals who are charged with intoxicated driving to the patient's commander.

Section 3E—Treatment Team (TT)

3.12. General. The primary objective of the Treatment Team is to guide the clinical course of treatment of the patient after examining all the facts.

3.13. Treatment Team Composition Roles, and Functions.

3.13.1. Membership of TT:

3.13.1.1. Commander and/or first sergeant.

3.13.1.2. Patient's immediate supervisor

3.13.1.3. ADAPTPM, or a privileged provider with administrative oversight responsibility for the ADAPT program. The ADAPTPM chairs the TT and determines the clinical course of treatment for patients in the ADAPT Program.

3.13.1.4. Certified substance abuse counselor and/or provider.

3.13.1.5. Medical consultant(s) as needed.

3.13.1.6. Any therapist concurrently involved in the care of the individual.

3.13.1.7. Other individuals as deemed necessary.

3.13.1.8. The patient unless deemed clinically inappropriate. In this case, the patient will be briefed on the treatment decisions of the TT.

3.13.2. If the patient is on flight status, a flight surgeon will be included in the TT meeting.

3.13.3. Commander or first sergeant, and supervisor involvement in the TT at key points in the patient's treatment and recovery is important. The commander or first sergeant, and supervisor must be involved at program entry, termination, and any time there are significant treatment difficulties with the patient. ADAPT personnel must brief commanders on patient progress at least quarterly--telephonically, individually, or within the TT.

3.13.4. Treatment Planning. The primary purpose of the treatment plan is to establish the frame work for the patient's treatment and recovery.

3.13.4.1. The treatment plan documents the level and intensity of care, incorporates issues, problem areas, life skill deficits, and goals identified during the biopsychosocial assessment, and identifies appropriate treatment resources to be utilized during the patients course of treatment.

3.13.4.2. The treatment plan will be comprehensive, individual specific, and stated in behavioral terms.

3.13.4.3. Treatment plans will be reviewed on a regular basis, at least quarterly, to ensure that the plan reflects status of the patient's progress toward effective substance abuse recovery and stabilization of other identified clinical issues.

3.13.5. The ADAPTPM, in consultation with the TT, makes a treatment decision within 15 duty days of the referral to the ADAPT Office. Reasons for delays must be documented in the outpatient mental health record on SF 600 and conveyed to the commander.

3.13.6. Documenting the TT. TT activity will be documented completely in the mental health record, and a brief overview of the TT activity will be placed in the outpatient medical record on SF 600.

Section 3F—Substance Abuse Treatment

3.14. Non-Clinical Services

3.14.1. All patients referred for substance abuse assessment who do not meet diagnostic criteria for alcohol abuse or alcohol dependence will be provided a minimum of 6 hours of awareness education. The only exceptions to this requirement are in instances where alcohol was not a factor in the referral or when the provider determines awareness education is clearly not warranted. Additional counseling addressing biopsychosocial issues identified in the assessment may be prescribed. Length of involvement will be determined based on the patient's presenting problems and agreed upon treatment or behavioral contract.

3.14.1.1. Substance abuse awareness education will incorporate information on individual responsibility, AF standards, legal and administrative consequences of abuse, decision making, dynamics of substance abuse, biopsychosocial model of addictions, values clarification, impact of substance abuse on self and others, family dynamics, and goal setting.

3.14.2. Individuals being processed for separation will be provided appropriate medical care (detoxification) prior to separation. Separation action will not be postponed because of a members participation in the ADAPT Program.

3.15. Clinical Services

3.15.1. Patients meeting the DSM IV diagnostic criteria for alcohol abuse or alcohol dependence will be entered into substance abuse treatment with the level and intensity of care determined by the ADAPTPM using current American Society of Addiction Medicine (ASAM) criteria.

3.15.2. A continuum of substance abuse care that is compatible with the patient placement criteria of the American Society of Addiction Medicine shall be provided. ASAM criteria reflect the philosophy of placing patients in the least intensive/restrictive treatment environment, appropriate to their therapeutic needs. Variable lengths of stay/duration of treatment shall be provided within a variety of treatment settings. The treatment program will reflect a multi-disciplinary approach to assist the patient to achieve full recovery, free of the negative effect of the substance abuse.

3.15.3. Program requirements will be individually tailored to meet the needs of the patient and include awareness education on the biopsychosocial concepts of addiction, defense mechanisms, self esteem/self concepts, family dynamics, relapse prevention, physical effects of substance abuse, stress management, anger management/assertiveness, goals and recovery plans, and other subject matter that TT deems necessary. Family involvement is strongly encouraged.

3.15.3.1. Individuals diagnosed with alcohol abuse or alcohol dependence will refrain from the use of alcohol during the initial phase of treatment, and will be strongly encouraged to continue to abstain during aftercare. Total abstinence is a critical treatment goal; however, because of the nature of alcoholism, relapses into drinking behavior are not uncommon and should be anticipated. A relapse by itself is not sufficient reason for program failure; however, relapses must be considered a significant threat to the patient's treatment and dealt with appropriately.

3.15.3.2. Involvement in self-help recovery groups (i.e. 12-step, rational recovery) is encouraged as an adjunct to treatment. The frequency of attendance is determined by the TT with the patient. The TT will encourage the patient to attend smoke-free recovery groups.

3.15.4. Patients will adhere to the treatment plan developed by the TT.

3.15.5. Requesting admission to an Substance Abuse Recovery Center (SARC). ADAPT staff will contact the SARC intake coordinator requesting admission of the patient.

3.15.6. Substance Abuse Recovery Centers:
David Grant Medical Center, Travis AFB CA
Medical Group, Eglin AFB FL
Malcolm Grow Medical Center, Andrews AFB MD
Scott Medical Center, Scott AFB IL
Medical Group, Sheppard AFB TX
Wilford Hall Medical Center, Lackland AFB TX
Wright-Patterson Medical Center, Wright-Patterson AFB OH
48th Medical Group, RAF Lakenheath UK
3rd Medical Group, Elmendorf AFB AK
Tri-Service SARC, Tripler Army Medical Center, Honolulu HI

3.15.7. Detoxification Prior to Treatment.

3.15.7.1. Patients being referred for in-patient treatment will be assessed to determine the level of detoxification services required. To the greatest extent possible, patient detoxification will be managed on an outpatient basis prior to inpatient treatment.

3.15.7.2. Patients assessed as requiring medically managed detoxification (in-patient) will be entered into an appropriate medical facility.

3.15.7.3. All patients utilizing aeroevacuation services must have 72 hours of monitored abstinence (inpatient or outpatient) prior to departure.

3.15.7.4. Local patients referred to a partial (day treatment) or inpatient substance abuse service may begin treatment immediately, if the history, physical examination, and other documentation indicates the patient can safely begin treatment. If, however, the patient experiences symptoms of apparent withdrawal, he or she will be re-assessed and detoxification protocol initiated.

3.15.8. Patients returning from the SARC will have a TT meeting convened within 10 duty days of return to assess the patient's progress during in-patient treatment and design a treatment plan for aftercare.

3.15.9. Use of Disulfiram (Antabuse), naltraxone, etc., in treatment programs will be strictly monitored by a physician or psychiatrist and the SARC director.

3.15.10. Outcome Measurements. The local ADAPT program will develop procedures to evaluate the effectiveness of its program. Procedures should include determining accuracy of patient assessments, appropriateness of treatment plans, proportion of patients successfully completing the treatment program, unforeseen complications in treatment process, and access time to assessment and treatment. Procedures should also include assessment of drinking behavior and duty performance at the 3, 6, and 12 month post discharge from intensive outpatient, partial hospitalization, variable length of stay, or in-patient treatment programs. Prevention services should assess the proportion of the target population provided substance abuse preventive education, range of preventive education offered, attendee satisfaction with the program, and appropriate performance/outcome measures.

3.16. Completing the Program.

3.16.1. Successful Completion. Patients will not be considered to have successfully completed treatment until they meet the DSM criteria for early full remission. The TT determines, based on DSM criteria, patient progress towards agreed upon goals and/or issues as stated in the treatment plan, when the patient is effectively in recovery and no longer requires program resources.

3.16.2. Failing the Program. The TT determines a patient to have failed the program based on a demonstrated pattern of unacceptable behavior, inability or unwillingness to comply with their treatment plan, or involvement in alcohol and/or drug related incidents after receiving initial treatment. The determination that a patient has failed treatment is based on the patient's repeated failure to meet and maintain Air Force standards (behavior), rather than solely on the use of alcohol. Individuals who have been determined as failing the ADAPT program shall be considered for administrative separation by their commander IAW AFI 36-3207, or AFI 36-3208.

3.17. Continuity of Care Following Intensive Outpatient, Partial or Inpatient Treatment Completion

3.17.1. The treatment team will meet within 10 days of a patient's completion of an intensive outpatient, partial day treatment, or inpatient treatment program to review progress and recommend a course of treatment for aftercare. Decisions regarding aftercare services will be based on a current assessment of status and will include establishment of an aftercare treatment plan identifying specific goals, interventions, and means to assess interventions.

3.17.2. Patients' progress will be monitored by the ADAPT staff at least monthly while the patient is in aftercare.

3.17.3. Determinations about a patient's availability for PCS or TDYs will be coordinated through the TT during the patient's course of treatment. Generally, patients diagnosed with alcohol abuse or alcohol dependence are restricted from worldwide duty for their first six months of treatment.

3.17.4. Patients on mobility status who are in aftercare should be carefully assessed by the TT. When appropriate, the TT should recommend in writing that the individual be temporarily removed from the mobility position during the period of aftercare.

3.17.4.1. Patients making minimal or unsatisfactory progress in recovery should not be allowed to proceed on TDYs or a PCS, except for mandatory PCS moves. The TT will recommend to the commander that the individual not be released. At times, exceptional circumstances may warrant other approaches.

3.17.4.2. When patients PCS, the ADAPT staff will forward one copy of the patient's outpatient mental health record to the gaining base's outpatient mental health clinic to ensure continuity of care is maintained.

3.17.5. Following intensive outpatient, partial or inpatient treatment, the SARC Program Director will provide a treatment summary, to include aftercare recommendations, to the ADAPTPM and commander.

3.17.6. Decisions regarding access to classified material, security clearances, PRP, flying status will be determined by governing instructions for each program.

3.18. The Use Of The Profile System To Monitor Patients in Treatment.

3.18.1. All patients diagnosed with substance abuse or dependence and entered into the ADAPT Program will be placed on an S4T profile indicating the patient is not worldwide qualified.

3.18.2. The ADAPT PM will continuously monitor patient status and progress in treatment to determine the appropriateness for continuation or termination of the profile.

3.18.3. Guidance concerning the use of medical profiles can be found in AFI 48-123, attachment 2.

3.18.4. Any privileged mental health provider can act as the profile review officer for patients in substance abuse treatment.

CHARLES H. ROADMAN II, Lt General, USAF, MC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

10. U.S.C. 8013

42. U.S.C. 290 dd2

Executive Order 9397

Executive Order 11478

DoD 1010.4, Alcohol and Drug Abuse by DoD Personnel, 25 Aug 80,

DoD Instruction 1010.5, Education and Training In Alcohol and Drug Abuse Prevention, 5 Dec 80,

DoD Instruction 1010.6, Rehabilitation and Referral Services for Alcohol and Drug Abusers, 13 Mar 85,

DoD Directive 1010.7, Drunk and Drugged Driving by DoD Personnel, August 10, 1983, with Changes 1 and 2;

DoD Directive 1010.10, Health Promotions, 11 Mar 86, With Change 1

ASD(HA) Policy OSD(HA) Memorandum on TRICARE Substance Abuse Treatment, 13 Feb 97,

AFI 31-501, Personnel Security Program Management,

AFI 36-2104, Personal Reliability Program (PRP),

AFI 36-2907, Unfavorable Information Files (UIF),

AFI 36-2910, Line of Duty (Misconduct) Determinations,

AFI 44-119, Medical Service Clinical Quality Management,

AFI 48-123, Medical Examinations and Standards

Abbreviations and Acronyms

AA—Alcoholic Anonymous

ADAPT—Alcohol & Drug Abuse Prevention & Treatment

AFPD—Air Force Policy Directive

ASAM—American Society of Addiction Medicine

BAT—Blood Alcohol Test

DRU—Direct Reporting Unit

DSM—Diagnostic Statistical Manual

DUI—Driving Under the Influence

DWI—Driving While Intoxicated

FOA—Field Operating Agency